Why Integrating Mental Health and Substance Abuse is Hard and What To Do About It – Implications for Criminal Justice

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A. Definition of Co-Occurring Disorders

In "A Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders", SAMHSA defines people with co-occurring disorders as "individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person…at least one disorder of each type can be diagnosed independently of the other". The report also states, "Co-occurring disorders may include any combination of two or more substance abuse disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). There are no specific combinations of….disorders that are defined uniquely as co-occurring disorders."

(www.samhsa.gov/reports/congress2002/foreword.htm)

B. Challenges of Different Theoretical Perspectives and Different Treatment Methodologies in Co-Occurring Disorders

1. Integrated Treatment versus Parallel or Sequential Treatment
- hybrid programs - staffing difficulties; numbers of clients and variability, but one-stop treatment
- parallel programs - use of existing programs and staff, but more difficult to case manage

2. Care versus Confrontation
- mental health - care, support, understanding, passivity; lack of mental capacity to make decision to participate in a mental health/drug court; mental health courts rarely or occasionally use jail for sanctions
- addiction - accountability, behavior change; drug courts commonly use jail and other sanctions for treatment nonadherence

3. Abstinence-oriented versus Abstinence-mandated
- treatment as a process, not an event – stages of change and motivational strategies
- respective roles in both approaches

4. Deinstitutionalization versus Recovery and Rehabilitation
- role of "least restrictive" setting
- role for individualized treatment with continuum of care

C. Definitions of Compliance and Adherence

Webster's Dictionary defines "**comply**" as follows: to act in accordance with another's wishes, or with rules and regulations. It defines "**adhere**": to cling, cleave (to be steadfast, hold fast), stick fast.

D. **The Coerced Client and Working with Referral Sources**

The mandated client can often present as hostile and resistant because they are at "action" for staying out of jail; keeping their driver's license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between "doing time" and "doing treatment". Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients and think this way, the 3 C's are important:

3 C's

- Consequences – It is within criminal justice's mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

- Compliance – The offender is required to act in accordance with the court's orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

- Control –The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts above to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care now at this point in time. The issues span the following:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create incentives for change and provide supports to allow change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

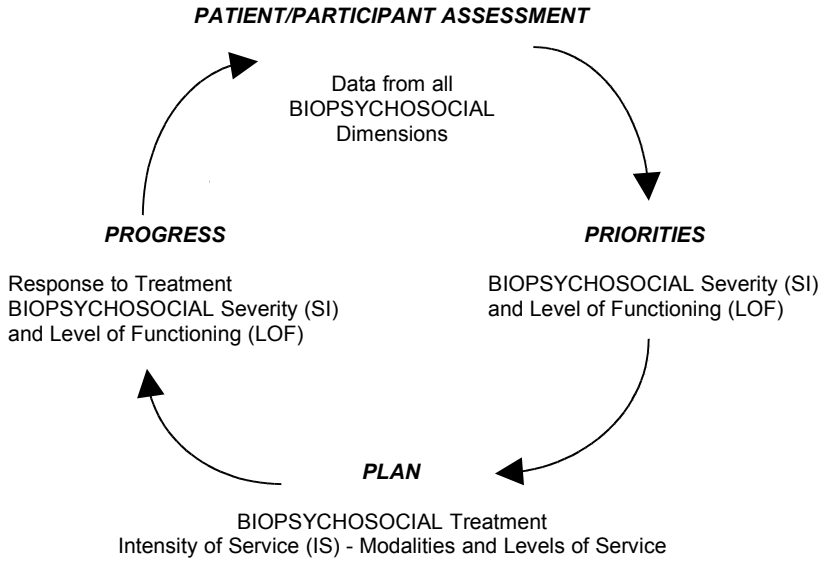
E. **Person-Centered Assessment and Individualized Treatment**

1. Multidimensional Assessment

- Because mental and substance-related disorders are biopsychosocial disorders in etiology, expression and treatment, assessment must be comprehensive and multidimensional to plan effective care. The common language of six assessment dimensions of the ASAM Criteria (*modified* for mental disorders in Second Edition, Revised, ASAM PPC-2R, 2001) are used to focus assessment/treatment.

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/*Cognitive* conditions and complications
4. *Readiness to Change*
5. Relapse/Continued Use/*Continued Problem* potential
6. Recovery environment

2. Individualized Treatment



3. Biopsychosocial Treatment - Overview: 5 M's

5 M's:

* Motivate - Dimension 4 issues; engagement and alliance building
* Manage - the family, significant others, work/school, legal
* Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
* Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
* Monitor - continuity of care; relapse prevention; family and significant others

4. Treatment Levels of Service - levels of care/service to match severity of problems:

I Outpatient Services
II Intensive Outpatient/Partial Hospitalization Services
III Residential/Inpatient Services
IV Medically-Managed Intensive Inpatient Services

F. **What Works to Achieve Good Outcomes in Mental Health and Drug Courts?**

- Enhanced collaboration among all agencies – team approach to screening and evaluation, crisis intervention, short-term treatment that includes suicide prevention, case management, counseling, psychotropic medication and community integration
- Increased awareness of the needs of substance-using clients in the criminal justice system
- Build strong collaborations – improved coordination and continuity of care
- Maintain good communication
- Recognize competing interests in developing procedures for drug and mental health court
- Consider changes for eligibility criteria as experience expands (Wolfe EL, Guydish J, Woods W, Tajima B (2004): "Perspectives on the drug court model across systems: a process evaluation" J. Psychoactive Drugs 36(3): 379-86)
- Increase drug court participation, treatment retention and completion rates (Fielding JE, Tye G, Ogawa PL, Imam IJ, Long AM (2002): "Los Angeles County drug court programs: initial results" J Subst Abuse Treat. 23(3): 217-24.
- Judicial supervision of community-based treatment
- Identification and referral shortly after arrest
- Regular hearings to monitor treatment progress and adherence
- Series of graduated sanctions – mental health courts use various creative methods of disposition of criminal charges to mandate adherence to community treatment. In contrast, drug courts commonly use jail and other sanctions for nonadherence. Mental health courts rarely or occasionally use jail for sanctions. (Griffin PA, Steadman HJ, Petrila J. (2002) The use of criminal charges and sanctions in mental health courts. Psychiatr Serv. 2002 Oct; 53(10):1285-9.)
- Mandatory drug testing
- Assurance of existing appropriate treatment slots (Steadman HJ, Davidson S, Brown C (2001): "Mental Health Courts: Their Promise and Unanswered Questions" Psychiatric Services 52(4): 457-458.)

G. **Gathering Data on Policy and Payment Barriers**

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or in adequate meeting of a client's needs can be a data point that sets the foundation for strategic planning and change
- Finding efficient ways to gather data as it happens in daily care of clients can help provide hope and direction for change:

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert the level of care and/or type of service that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity.	
Level of Care/Service Received - If the most appropriate level/service is not able to be utilized, insert the most appropriate placement/service available and circle the Reason for Difference between Indicated and Received Level/service	
Reason for Difference - Circle only one number -- **1**. Level of care or Service not available; **2**. Provider judgment; **3**. Client preference; **4**. Client is on waiting list for appropriate level/service; **5**. Level of care or Service available, but no payment source; **6**. Geographic inaccessibility; **7**. Family responsibility problems e.g., no childcare; **8**. Language; **9**. Not applicable; **10**. Not listed.	

LITERATURE REFERENCES AND RESOURCES

"Addiction Treatment Matching – Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria" Ed. David R. Gastfriend. The Haworth Medical Press. 2004.

Center for Substance Abuse Treatment. "Substance Abuse Treatment for Persons With Co-Occurring Disorders" Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005
(TIP 42 available online at Health Services/Technology Assessment Text (HSTAT) section of National Library of Medicine Web site at URL: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441)

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
(American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; (800) 844-8948)

Mee-Lee, David (2001): "Treatment Planning for Dual Disorders". Psychiatric Rehabilitation Skills Vol.5. No.1, 52-79.

CLIENT WORKBOOKS AND INTERACTIVE JOURNALS

1. "Successful Living with a Dual Disorder" – Motivational, Educational and Experiential (MEE) Journal System. Interactive journaling for clients. This Journal is designed specifically for individuals who are suffering with a dual disorder. It provides important information that allows clients to understand the facts and challenges regarding their addiction and mental disorder.
To order: The Change Companies at 888-889-8866. www.changecompanies.net.

RESOURCE FOR HOME STUDY AND ONLINE COURSES

1. "Dilemmas in Dual Diagnosis Assessment, Engagement and Treatment" By David Mee-Lee, M.D. This home study or online course (with CEU's) is designed to improve practitioners' abilities to assess, engage, and treat people with co-occurring mental health and substance use problems. Practical strategies and methods are offered to help change interviewing methods, treatment planning and documentation, program components, range of services, and policies to better engage the dually diagnosed client.

Professional Psych Seminars, Inc. Agoura Hills, CA Toll-free phone: (877) 777-0668. Website: www.psychsem.com

2. Hazelden's Clinical Innovators Series

"Applying ASAM Placement Criteria" DVD and 104 page Manual with more detail based on the DVD with Continuing Education test (10 CE hrs), 75 minute DVD

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3. Motivational Interviewing and Ambivalence – Principles of Motivational Interviewing; Spirit of Motivational Interviewing; Working with Ambivalence - Disc 3 of a Five Part Series Workshop

4. Establishing the Treatment Contract; Role Play – What, Why, How, Where and When to establish the Treatment Contract; and a role play with a "17 year old young man" to illustrate this technique - Disc 4 of a Five Part Series Workshop

5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist's Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

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